STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085009	A. BUILDING _____ B. WING _____	02/28/2017

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from February 21, 2017 through February 28, 2017. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 55. The Stage 2 sample totaled 23 residents. Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN- Licensed Practical Nurse; CNA - Certified Nurse's Aide; RNAC - Registered Nurse Assessment Coordinator; Analgesia - relief of pain; eMAR - Electronic Medication Administration Record; Diabetes Mellitus (DM) - disease where blood sugar levels are too high; Divaloproex Sodium - medication used to treat various types of seizure disorders, manic episodes related to bipolar disorder (manic depression) and to prevent migraine headaches; EMR - Electronic Medical Record; Fingerstick - test to determine blood sugar (glucose); insulin - injected medication to control blood sugar; i.e. - that is to say; MDS (Minimum Data Set) - standardized	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/21/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 assessment form used in nursing homes; mL (milliliter) - unit of liquid volume; Non-pharmacological - non-medication; Pre - before; Post - after; PRN - as needed; sliding scale- dosage of insulin based on blood sugar levels; MAR-medication administration record; TB-tuberculosis, infectious disease of the lungs; ml-milliliter-unit of volume; Alzheimer disease-a progressive disease that destroys memory and other mental function; Pneumonia-infection that inflames the air sacs of lungs; Dementia-a group of thinking and social symptoms that interferes with functioning; Nebulizer-breathing apparatus used to deliver medication to the patient.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 157		5/26/17

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F 157	Continued From page 2 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to consult with the doctor when a resident's condition changed for one (R40) out of 23 sampled residents. Findings include: Cross Refer F309, Example 1	F 157	F157 CR POC 279 & POC 309 A) Resident #40 had no identified negative outcome and the medical record has been reviewed by the Nursing Unit	

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F 157	Continued From page 3 Review of R40's clinical record revealed: 11/20/16 - Physicians' orders included sliding scale insulin to be given according to the resident's blood glucose fingerstick, with insulin to be given when the fingerstick was 150 or higher. For glucose 400 and higher, the resident would be given insulin and the doctor called. 12/9/16 - Physicians' orders changed the sliding scale so that R40 would start receiving insulin when the fingerstick was 300 or higher. If 450 or higher, then the physician was to be called for insulin orders. November 2016 through February 2017 - Review of eMARs, nursing notes and physicians' orders found the doctor was not consulted / called as ordered for three high glucose fingersticks: 11/28/16 (7:30 AM): 408 12/29/16 (4:30 PM): 450 2/14/17 (11:30 AM): 457 During an interview with E2 (DON) on 2/17/17 around 3:15 PM, after independently reviewing the eMARs, nursing notes, physicians' orders and having staff check the communication book on the unit, E2 confirmed there was no evidence the doctor was called for three high fingerstick glucose readings. This finding was reviewed with E1 (NHA) and E2 on 2/28/17 at 3:00 PM.	F 157	Manager and the physician and no new orders written. B) All residents may be affected by this practice. DON/Designee will conduct random medical record audits of residents with a diagnosis of diabetes and orders for finger stick blood sugar (FSBS) levels ordered,to ensure that physician notification occurred according to ordered FSBS parameters for physician notification. C)ADON/Staff Developer will re-educate all nursing staff on the requirement and importance of physician notification for all resident changes as well as the appropriate documentation of such. A review of the Physician Notification Policy will be completed. D)The DON/Designee will complete random audits of residents with FSBS's ordered by the physician one (1) time per week for three (3) months to ensure blood sugar levels outside of parameters included physician notification. Results will be reviewed and discussed at the monthly QA meetings and the quarterly QA/QI meetings. Attachment #1 and #2	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20	F 279		5/26/17

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F 279	Continued From page 4 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 279		

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F 279	Continued From page 5 (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop comprehensive care plans for identified needs and failed to ensue that goals were measurable for 3 (R60, R40, and R38) out of 23 sampled residents. Findings include: Cross Refer 309, Example 3. 1. R60's care plan for pain initiated 9/29/16 and last updated 11/1/16 identified R4's goals for pain management as: - I will not have an interruption in normal activities due to pain through the review date -I will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. The interventions for R60's care plan for pain were:	F 279	F279 CR POC F157 & POC F309 A1)Resident #60's care plan was revised to include individualized measurable goals and interventions for pain management, including non-pharmacological interventions, measurable pain goal and pain scale by asking the resident his/her level of pain verses documenting effective after pain interventions provided and using a pre and post pain intervention scale. A2)Resident #40's care plan was revised to include individualized measurable goals and interventions for pain management, including non-pharmacological	

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F 279	Continued From page 6 -anticipate my need for pain relief and respond immediately to any complaints of pain I may have. - Identify and record my previous pain history and management of that pain and impact on my function -identify my previous response to analgesia including pain relief side effects and impact on my function. -monitor me and document for side effects of my pain medication, report any occurrences to my physician. This goal was not measurable since the care plan did not include the resident's acceptable pain goal score. The care plan did not include non-pharmacological interventions useful for this resident nor the type of pain scale this resident uses. Cross Refer 309, Example 2. 2. Review of R40's clinical records revealed: 11/1/9/16 - Care plan problem for potential for pain included the goal that pain will be controlled to an acceptable level. Interventions included: Administer pain medication as ordered; Use pain scale when assessing before and after medication administration; Document/report complaints and non verbal signs of pain. This goal was not measurable since the care plan did not include the resident's acceptable pain goal score. The care plan also did not include non-pharmacologic interventions useful for this resident nor the type of pain scale this resident uses. During an interview with E2 (DON) on 2/27/17 between 3:07 - 3:45 PM while E2 was reviewing	F 279	interventions, measurable pain goal and pain scale by asking the resident his/her level of pain verses documenting effective after pain interventions provided and using a pre and post pain intervention scale. A3)Resident #38's care plan was revised to address pain and a mood disorder/behaviors. The care plan revisions included individualized measurable goals and interventions, addressing non-pharmacological interventions for pain management,reflecting an acceptable pain goal and pain scale by asking the resident his/her level of pain verses documenting effective after pain interventions provided. The care plan was also modified to include a plan for behaviors with measurable goals related to the use of Divalproex Sodium (Depakote) and was reviewed with the physician and continues to be used for mood stabilization. B)All WBC residents have a potential care need for pain management and behavior management, therefor random audits will be completed weekly by the DON/Designee for two months, on all new admissions as well as residents receiving pain medications and behavioral related medications. The electronic medical record system in place within WBC is called "point click care", the NCP (nursing care plan), physician orders and Medication administration information will	

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F 279	Continued From page 7 R40's eMARs, nursing notes and physicians' orders for PRN medication administrations the surveyor informed the DON that R40's pain care plan was rather sparse and identified the missing areas. E2 acknowledged s/he has been at the facility since December, 2016 and care plans were among the items that needed to be reviewed. Cross Refer 309, Example 4. 3. R38's care plan for pain initiated 10/13/16 and last updated 12/14/16 identified R38's goals for pain management as: - I will not have an interruption in normal activities due to pain through the review date - I will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. The interventions for R38's care plan for pain were: - Anticipate my need for pain relief and respond immediately to any complaints of pain I may have. This goal was not measurable since the care plan did not include the resident's acceptable pain goal score. The care plan did not include non-pharmacological interventions useful for this resident nor the type of pain scale this resident uses. Cross Refer 329, Example 1. 4. R38's care plan initiated 10/13/16 and last updated 12/14/16 does not include a plan for behaviors. 12/06/16 - Physicians' orders for Divalproex Sodium Capsule Delayed Release Sprinkle 125mg give 1 capsule by mouth two times a day	F 279	be reviewed to ensure pain as well as behavioral goals are measurable and that all physician orders are followed. The audit will include a review of pain assessment scales being implemented appropriately both pre and post all interventions as well as the plan of care has measurable behavioral goals and all psychopharmacologic medications and or non-pharmacological interventions are care planned for. C)The ADON/Staff Developer will educate all nurses on ensuring pain goals are measurable and pain scales are in place and being utilized to reflect each persons pain management plan of care. She will re-educate all nurses on the Pain Management Policy and the Pain Status Report for the cognitively impaired and the non-cognitively impaired. Education will include how to document on residents when they are assessed and are sleeping. Education will also be provided on the care planning for all behavioral goals, that they are measurable and interventions include non-pharmacological interventions. Education will include a review of the psychopharmacologic medication policy and the importance of following the prescribed treatment plan/physician orders. All nurses will be re-educated on the Point Click Care Section addressing effectiveness for prn medications/treatments, the Populate Note Details, Entering Pre and Follow Up Pain Levels, both on the numerical scale for those cognitively able to utilize such scale and the PAINAD for Cognitively	

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F 279	Continued From page 8 for behaviors. During an interview with E5 (RN) at 12:45 PM on 2/28/16 it was confirmed that R38 did not have a care plan for behaviors. Findings were reviewed with E1 (NHA) and E2 (DON) on 2/28/17 at 3:00 PM.	F 279	Impaired Residents. D)The RNAC/MDS Coordinator will review the care plans of all WBC residents with pain management and behavioral care needs to ensure that individualized measurable goals and interventions, including non-pharmacological interventions are addressed. Following this complete review she will conduct random audits for two months and then follow the facility care plan review schedule that is in place. Attachment #3,#4A,#4B,#5,#6	
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309		5/26/17

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F 309	Continued From page 9 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for three (R40, R60 and R38) out of 23 sampled residents. For R40, the facility failed to follow physicians' orders for elevated blood glucose levels. For R40, R60 and R38 the resident's level of pain was not reassessed post-administration with the same pain scale used pre-administration after PRN pain medications. Findings include: Blood Glucose Fingersticks 1a. Review of R40's clinical records revealed: 11/18/16 - Admission to the facility with multiple diagnoses including diabetes. 11/20/16 - Physicians' orders included sliding scale insulin to be given according to the	F 309	F309 A1)Resident #40's clinical record was reviewed by the physician related to the FSBS and pain management (CR POC F157 and F 279) no new orders were received and this resident had no identified negative outcomes. A2)Resident #60's clinical record was reviewed and the record reflected the pain medication administered was "effective", the plan of care was revised related to pain management to ensure documentation of a pre and post numeric pain scale for all pain interventions is implemented(CR POC F279). A3)Resident #38's clinical record was reviewed and the record reflected the pain medication given was "effective" the plan	

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F 309	Continued From page 10 resident's blood glucose fingerstick, with insulin to be given when the fingerstick was 150 or higher. For finger stick glucose 400 and higher, the resident would be given insulin and the doctor called. 11/28/16 (7:30 AM) - R40's eMAR showed a fingerstick of 408 and the resident received the ordered insulin. Review of nursing notes found no evidence the physician was called. 11/29/16 - Care plan problem for diabetes (last revised 2/6/17) included the goals to be free from signs and symptoms of high or low blood glucose and have no complications related to diabetes. Interventions included to administer diabetes medications as ordered and monitor for side effects. 12/9/16 - Physicians' orders changed the sliding scale so that R40 would start receiving insulin when the fingerstick was 300 or higher. If 450 or higher, then the physician was to be called for insulin orders. December 2016 through February 2017 - Review of R40's eMAR, nursing notes and physicians orders discovered no evidence the doctor was notified or any insulin was given for fingersticks 450 and above on: - 12/29/16 (4:30 PM): fingerstick 450 - 2/14/17 (11:30 AM): fingerstick 457 During an interview with E2 (DON) on 2/17/17 around 3:15 PM, after independently reviewing the eMARs, nursing notes, physicians' orders and having staff check the communication book on the unit, E2 confirmed there was no evidence the doctor was not called for three high fingerstick	F 309	of care was revised related to pain management to ensure documentation of a pre and post numeric pain scale for all pain interventions is implemented (CR POC F279). B)Cross Reference POC F157 B &F279 All current WBC residents have the potential to be affected by this practice. C) Cross Reference POC F157 C & F279 An audit was completed on 3/7/17 of all WBC residents with diagnoses of diabetes, pain and behavior management care needs to ensure physician orders for a sliding scale insulin were followed, behaviors were care planned and pain effectiveness was evaluated using a numeric scale with a pre and post interventions. The DON/RN Unit Manager or designee will review and monitor the physician orders, behavior care plans and pain effectiveness utilizing a monitoring tool to ensure that the staff is providing the necessary care and services once a week for 6 weeks. D) Cross Reference POC F157 D & F279 The RNAC/MDS coordinator will review at random the comprehensive assessments and the care plans of the WBC residents to ensure that the care plan reflects measurable goals and interventions addressing the pain management, diabetes and behaviors to ensure that each resident receives the services necessary to attain their highest practical level of functioning that is consistent with	

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F 309	Continued From page 11 glucose readings and that the resident did not receive insulin for two of them. Pain Assessment October, 2000 - Pain Management policy (last revised January 2017) included the following: - Information should be obtained directly from the resident. If the resident is unable to participate, this information may be obtained from the family or caregiver. - Non-verbal and verbal behaviors may be observed if a resident is unable to communicate pain... - Consider non-pharmacological interventions to help manage pain either independently or in conjunction with pain medication regimen. - The resident's pain is monitored each shift and documented on the MAR (i.e., experiencing pain or not, and level of pain). April, 2002 - The pain management standards approved by the American Geriatrics Society included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. 1b. Review of R40's clinical records revealed: 11/18/16 - Physicians' order for pain medication to be given as needed every 4 hours for pain. 11/19/16 - Care plan problem for potential for pain included the goal that R40's pain will be controlled to an acceptable level. Interventions included to:	F 309	the comprehensive assessment and plan of care. DON/designee will review all care and services provided to the residents. Compliance outcome will be reviewed at the QA/QI meetings. Attachment #6,#7,#8	

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F 309	Continued From page 12 Administer pain medication as ordered; Use pain scale when assessing both before and after medication administration; Document/report complaints and non verbal signs of pain. November 2016 through February 2017 - eMARs showed that all doses of the PRN pain medication had a pain score documented prior to administration and 'E' for effective after administration. Review of eMARs and nursing notes discovered that 39 out of 49 PRN pain medication administrations did not have a post numeric pain rating score. - November: 14 out of 16 doses - December: 2 out of 4 doses - January: 10 of 14 doses - February: 13 of 15 doses During an interview with E4 (RN) on 2/27/17 at 2:08 PM when asked about which pain scale is used for R40, E4 said "for me she is usually able to state." The nurse was not sure if different pain scales were available in the computer when administering the PRN. When asked about a nonverbal scale, E4 thought there was one in the binder on the medication cart, but was not able to find the non verbal scale in the binder. During an interview with E2 (DON) on 2/27/17 between 3:07 - 3:40 PM to review pain assessment expectations for PRN medication administration, E2 stated the nurse should document the pain rating after PRN medication administration. E2 acknowledged that the nurse can document effective but was not sure if a pain score could be written in the eMAR. Surveyor informed E2 that several nurses did record their post pain rating severity score on the eMAR. When asked about post rating if the resident was	F 309		

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F 309	Continued From page 13 sleeping, E2 would not expect the resident to be disturbed. Surveyor stated that a nonverbal pain scale could be used if the resident was sleeping. 2. Review of R60's clinical record revealed: 9/15/16 - R60 received an order for a pain medication to be received every 4 hours as needed. R60's care plan for pain initiated 9/29/16 and last updated 11/1/16 identified R60's goals for pain management as no interruption in normal activities due to pain, and adequate relief of pain or ability to cope with incompletely relieved pain through the review date. The interventions for R60's care plan for pain were to anticipate need for pain relief and respond immediately to any complaints of pain identify and record previous pain history and management of that pain and impact on function, identify my previous response to analgesia including pain relief side effects and impact on my function, monitor me and document for side effects of my pain medication, and report any occurrences to my physician. December 2016 through February 2017 - eMARs showed that all doses of the PRN pain medication had a pain score documented prior to administration and 'E' for effective after administration. Review of eMARs and nursing notes discovered that 67 out of 133 PRN pain medication administrations did not have a post numeric pain rating score - December: 25 out of 48 doses - January: 22 out of 49 doses - February: 20 out of 36 doses During an interview on 2/28/17 at 10:30 AM with	F 309		

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F 309	Continued From page 14 E2 (DON) it was reported that the facility did not expect staff to use the same pain scale to measure effectiveness of prn pain medication for both pre-administration and post-administration of pain medication assessments. 3. Review of R38's clinical record revealed: 10/3/16 - R38 received an order for a pain medication to be received every 6 hours as needed. R38's care plan for pain initiated 10/13/16 and last updated 12/14/16 identified R38's goals for pain management as: - I will not have an interruption in normal activities due to pain through the review date - I will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. The interventions for R38's care plan for pain included: - Anticipate my need for pain relief and respond immediately to any complaints of pain I may have. January 2017 and February 2017 - eMARs showed that all doses of the PRN pain medication had a pain score documented prior to administration and after administration the scale used was E=Effective, I=Ineffective, and U=Unknown. Review of eMARs and nursing notes revealed that 10 out of 23 PRN pain medication administrations did not have a post numeric pain rating score. - January 2017: 5 out of 12 doses - February 2017: 5 out of 11 doses Findings were reviewed with E1 (NHA) and E2 (DON) at 3:00 PM on 2/28/17.	F 309		

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F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 329		5/26/17

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F 329	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R38 and R40) out of 23 sampled residents the facility failed to provide an adequate indication of use and appropriate monitoring for ordered medications. Findings include: 1. Review of R38's clinical record revealed: 10/03/16 - Admission to the facility and physicians' orders for Divalproex Sodium two times a day for behaviors. [There were no specific behaviors or other diagnosis listed] MDS Assessments (Admission-10/10/16, re-Admission-12/8/16, and Medicare required-12/15/16) - no behavioral symptoms exhibited. Care Plan last reviewed on 12/14/16 - no behaviors planned for R38. No evidence of behavior monitoring or indication for use related to the use of this medication were found in resident record. During an interview with E5 (RN) at 12:45 PM on 2/28/17 it was confirmed that there was no indication for the use of the Divaloproex Sodium ordered for R38. E5 explained that R38 was admitted from another facility on the medication for behaviors and the facility did not identify what behavior it was being used for. Behaviors had not been exhibited since R38 was admitted to the current facility. 2. Review of R40's clinical record revealed:	F 329	F329 A1) Resident #38's record review revealed she came to the facility on this medication and the medication was used in conjunction with her medications for depression as a mood stabilizer. The care plan has been revised to address the use of this medication and the behaviors identified to monitor. CR POC F279 and F309. A2)Resident #40's clinical record was reviewed and revised to address prn medications and documentation in place required for administration of all prn medications. B) All residents may be affected by this practice. All medications that a resident has ordered should have a corresponding diagnosis and plan of care that goes with it, including prn medications which should specify what symptoms the prn is being given to treat and effectiveness of treatment documented. C) The RNAC/MDS Coordinator will review the Nursing Care Plans, Assessments along with physician orders according to the established current schedule to ensure that all orders are care planned appropriately. The RN Unit Manager along with the RN who completes the monthly Medication Recap's will review medications administered to ensure that administration	

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F 329	Continued From page 17 11/18/16 - Admission to the facility after hospitalization for pneumonia. 11/19/16 - Physicians' orders included an inhaled nebulizer medication to be given as needed every 4 hours for pneumonia shortness of breath. November 2016 through February 2017 - Review of eMARs and nursing notes discovered the inhaled medication was received three times. November 19 and December 31: no symptoms listed in the eMAR or nursing notes February 21: nursing note stated medication given "to help with some of her congestion." There was no evidence that the resident had shortness of breath, the reason for which the medication was ordered, for any of these PRN administrations. During an interview with E2 (DON) on 2/27/17 between 3:07 PM and 3:40 PM when reviewing the missing indication for the inhaled medication, E2 was provided with written information listing the dates the medication was administered without evidence of the need. No further information was made available regarding the indication for use of these administrations. These findings were reviewed with E1 (NHA) and E2 on 2/28/17 at 3:00 PM.	F 329	documentation is complete and indicates the medication was used for the ordered situation/signs and symptoms. Reviews will be reported to the DON/Designee to be discussed at Standard of Care Meeting, monthly. The ADON/Staff Developer will re-educate all nurses on the Medication, Unnecessary Policy. D) A review by the DON/Designee of the pharmacy consultant report,the reviews completed by the RNAC, RN Unit Manager and the RN doing the Monthly Medication Recap's, all information will be shared and discussed at the QA/QI meeting for recommendations. Attachment #9	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		5/26/17

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F 371	Continued From page 18 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to prepare and serve food in accordance with professional standards for food service safety. Food preparation equipment was not clean and serving dishes were not stored under sanitary conditions. Findings include: 2/19/17 - During the initial kitchen tour between 9:04 AM - 9:20 AM the following was discovered: - can opener across from walk in refrigerators had dried red/brown substance on and around the blade. This has the potential of contaminating canned foods opened with the dirty can opener. - stainless pans in storage had moisture between two small square pans, two long narrow pans,	F 371	F371 A) The can opener and the 16 pans identified in the statement of deficiency report were immediately removed, scrubbed, rinsed, sanitized and air dried during the initial kitchen tour which was on the first day of the survey, 2/21/17, Tuesday. B) All residents may be affected by this practice. Members of the production team were re-educated on sanitation procedures on 2/22/17 by the Director of Culinary Nutritional Services and members of the sanitation team were	

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F 371	Continued From page 19 and 12 large rectangular pans. These findings were immediately confirmed and rectified by E11 (Dietary Director) and E12 (Chef Manager). These findings were reviewed with E1 (NHA) and E2 (DON) on 2/28/17 at 3:00 PM.	F 371	re-educated on 2/23/17 by the Chef. C) A monitoring log will be used daily to check for compliance. The supervisor/designee will add this to their daily walk through check list and then initial and date accordingly. D) The chef/designee will conduct these audits daily for 4 weeks, and then weekly for 2 months to ensure compliance. Audit findings will be reviewed at the QA/QI meeting for review and recommendations. Attachment #10,#11	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient	F 431		5/26/17

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F 431	Continued From page 20 detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure that for one out of three controlled drug log books, that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled. Errors of two documented medication administration for	F 431	F431 A) Resident #4's medication log sheet was reviewed by the DON on 2/27/17 and the document reflected that all medication doses administered were administered correctly, as ordered by the physician.	

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F 431	Continued From page 21 entries of amount remaining were identified for R4. Findings include: On 11/30/16 R4 had an order to start anti-anxiety medication (medication to help with anxiety/nervousness) 0.25 ml daily. During medication storage inspection of medication cart "1" on 2/27/17 at 2:01 PM with E7 (RN),a nurse orientee, medication log sheets for R4's anti-anxiety medication appeared to document on 1/17/17 18 ml in the amount remaining column, then on 1/18/17 17.25 ml in the amount remaining column indicating that 0.75 ml were possibly administered to R4, whose ordered dose for her anti-anxiety medication was 0.25 ml. Then on 1/23/17 16 ml was documented in the amount remaining column and on the following dose,1/24/17 15.50 ml indicating that 0.5 ml was possibly administered to R4. It is unclear what the facility's process was for reconciling the discrepancies between the log and the actual medication bottle. Immediately following the medication storage inspection on 2/27/17 at 2:10 PM E6 (RN) nurse on the floor confirmed the reconciliation sheet should have been documented as 17.75 ml of R4's anti-anxiety medication remaining if the correct dose was given on 1/18/17. On 2/27/17 at 2:12 PM E6 accompanied the surveyor to do a visual inspection of the medication, which appeared to have the amount documented on the reconciliation sheet at present. During an interview on 2/27/17 at 2:15 PM with	F 431	There were 2 incidents where two nurses failed to reconcile or document correctly the number of amount of remaining liquid medication after they gave the correct dose, they subtracted incorrectly. The liquid medication visible in the bottle did reflect the correct amount that should be in the bottle,based on when the medication was received and the amount in the container and the number of doses given as well as a documented spillage. Both nurses that incorrectly subtracted were made aware of the concern and both completed statements as well as stated an understanding of the requirement to correctly keep records on all medications and the controlled substances as required to have a system to ensure all controlled drugs are maintained and periodically reconciled on 2/27/17. B) All residents may be affected by this practice. All Medication Log Sheets were immediately reviewed by the Unit Manager RN and all were found to be correctly completed and medication was correctly reconciled on 2/28/17. C) The 11pm-7am RN Charge will review all WBC controlled substance medication logs on a weekly basis and will document the review and indicate compliance and or non-compliance. For all non-compliance with record keeping an investigation will be initiated and reported per the Medication and Controlled Substance Policy. The pharmacy consultant will review the	

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F 431	Continued From page 22 E5 (RN) and unit manager on R4's unit, it was reported that the reconciliation was a math error and that this was the first time facility staff was aware. During an interview on 2/27/17 at 2:19 PM with E3 (ADON) it was confirmed that there was no change in the amount of anti-anxiety medication that R4 was to be receiving. On 2/27/17 at 3:00 PM a review of R4's nursing notes for the month of January 2017 did not reveal any documentation explaining the discrepancy of reconciliation on 1/18/17 and 1/24/17. During an interview on 2/28/17 at 10:28 AM with E2 (DON) and E1 (NHA) it was reported that both reconciliation's recorded were "math errors" and the R4 received the ordered dose of her anxiety medicaton. E2 confirmed that the facility did not recognize the error in reconciliation until 2/27/17 when it was reported to staff by the surveyor. E2 was unable to explain the facility's system for ensuring reconciliation errors does not occur. On 2/28/17 at 10:28 AM in the presence of E2 , E8 (LPN) confirmed that R4 received the correct dose of anti-anxiety medication on 1/24/17 and that a math error was made on the reconciliation sheet in the amount remaining. On 2/28/17 at 12:24 PM a written statement was submitted from E9 (LPN) who was the administering nurse on 1/17/17 confirming that R4 received the correct dose and that a math error was made on the reconciliation sheet in the amount remaining.	F 431	Medication Log sheets monthly to ensure accurate records and appropriate handling of medications is completed. The DON/Designee reviews all controlled substance sheets upon their completion for review that documentation reflects accurate receiving and disposition and that the Controlled Substance policy is followed correctly shift to shift as well as the weekly reviews completed by the 11-7 Charge Nurse. D) The reviews completed on medication log sheets and the pharmacy consultant reviews will be shared at the facility QA/QI meetings for review and further recommendations. Attachment #12, #13	

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F 431	Continued From page 23 This finding was reviewed with E1 (NHA) and E2 on 2/28/17 at 3:00 PM.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a	F 441		5/26/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085009	A. BUILDING _____ B. WING _____	02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT MANOR HOUSE	1001 MIDDLEFORD ROAD SEAFORD, DE 19973

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 24 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, it was determined that the facility failed to ensure that completed Tuberculosis (TB) screenings were done for 2 out of 5 (R40 and R88) residents reviewed and/or failed to follow their own screening for TB policy and procedures. One (E13) out of 20 staff reviewed failed to have evidence of a completed TB screening upon hire.	F 441	F441 A1) E13 received a PPD on 2/28/17 and it was read on March 2, 2017 and was 0mm, negative. A2) R40's immunizations are being reviewed with the physician for further	

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F 441	Continued From page 25 Findings include: The facility's Resident and Employee Screening for TB Policy/Procedures document with a revision date of 4/2015 included the following information: All newly admitted residents will be screened using the two step TB skin test. The screening will be documented and will include the date, time the test was administered, name and manufacturer of the injected solution, the lot number, the dosage administered, the expiration date of the solution, the site in which the injection was given and the initials (name) of the person who administered the test. It was unclear how the test could have been read when there was no site location as to where the test was administered for both residents. 1. R40's EMR had documentation dated 11/27/16 for the TB screening test was read by staff but no evidence that the screening had ever been conducted 48-72 hours prior to reading the results. 2. R88's EMR had documentation dated 12/15/16 that the TB screening test was read by staff but no evidence that the screening had ever been conducted 48-72 hours prior to reading the results. During an interview on 2/28/17 at 11:25 AM with E5 (RN) it was revealed that there was no evidence that the above TB screening for R40 and R88 were signed off (initialed by staff) as being administered. There was no evidence per facility policy as to what amount of testing solution was used, the type of injection, the injection site	F 441	orders related to screening. Resident has no symptoms of respiratory compromise. A3) R88's immunizations are being reviewed with the physician for further orders related to screening. B1) All residents may be affected by this practice. A complete review of all residents Immunization Record is being conducted by the ADON/Infection Control nurse. Information from paper records will be entered in the Point Click Care Immunization records to ensure all required immunizations are accurately recorded. The ADON will work with the HR assigned designee to ensure all newly hired employees have all required immunizations. C) All nurses will be re-educated on the Resident and Employee Screening for Tuberculosis policy by the ADON/Staff Developer. All newly admitted residents will be reviewed by the Unit Manager, within 14 days after admission, to ensure that required Tuberculosis testing has been administered as ordered and properly documented in the Point Click Care Electronic Immunization Record. D) DON/Designee will review newly admitted resident and new employee hire Tuberculosis information monthly with the unit manager and the ADON/Infection Control Nurse and then once a month thereafter. Tuberculosis screening compliance outcomes will be reviewed at	

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F 441	Continued From page 26 location, the manufacturer of the injected solution, and the expiration date of the solution. 3. E13 (CNA) was hired on 11/16/16. The facility had documented TB screening dated 4/19/16 and 6/22/16 but none at the time of employment. These findings were reveiwed with E1 (NHA) and E2 (DON) on 2/28/17 at 3:00 PM. During the exit conference E2 stated that E13 just had her TB screening done earlier in the day.	F 441	the QA/QI meetings. Attachment #14,#15A,#15B	
F 463 SS=D	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on surveyor observations and a staff interview, it was determined that the facility failed to ensure the callbell system was fully functional for one (Room 25) out of 25 rooms checked during multiple days of the survey. Findings include: Surveyor observations: On 2/22/17 at approximately 10:15 AM- the callbell cord was wrapped tightly around the metal grab bar in the bathroom, callbell did not activate when pulled.	F 463	F463 A) Room 25's call bell cord was un-wrapped from the metal grab bar in the bathroom and checked to ensure it was working on 02/28/17. B) All residents may be affected by this practice. All Rooms, bedrooms and bathrooms, in WBC, were inspected on 02/28/17 to ensure call bells were available, within reach of the resident,functioning properly and not	5/26/17

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F 463	Continued From page 27 On 2/23/17 on three separate occasions (9:15 AM, 12:03 PM, and 1:03 PM) the cord was observed tightly wrapped around the grab bar in the bathroom and callbell did not activate when pulled. On 2/27/17 on two occasions (7:37 AM and 8:35 AM) the cord was observed wrapped around the grabbar with some of the cord hanging below the grab bar, callbell did not activate when pulled. During an interview on 2/27/17 at 8:35 AM with E10 (CNA) acknowledged that the callbell cord was wrapped around the grab bar and that it had been that way when he/she came in the room this morning. The surveyor demonstrated the emergency callbell would not activate when pulling the cord below the grab bar. E10 then unwrapped the cord. These findings were reviewed with E1 (NHA) and E2 (DON) on 2/28/17 at 3:00 PM.	F 463	wrapped around grab rails, all call bells were functioning. Random audits will be completed for bathroom call bell cords. Bathroom call light cords were inspected for proper length and all light cords hang freely in the bathrooms as required. The inspection resulted in no other call bells found wrapped around the bathroom grab bar. C) The ADON/Designee will conduct education for all staff in WBC on checking the call bell cords and ensuring they are hanging freely and accessible when they are in the bathrooms/rooms providing daily care. D) The DON/Designee and NHA/Designee will conduct call bell/call bell cord audits throughout WBC once per week for one month and then random audits once per month. Results of the audits will be presented to the QA/QI committee for review and recommendations. Attachment #16	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

ACILITY: Willowbrooke Court At Manor House **DATE SURVEY COMPLETED: February 28, 2017**

	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from February 21, 2017 through February 28, 2017. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 55. The Stage 2 sample totaled 23 residents. **Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on February 28, 2017: F157, F279, F309, F329, F371, F431, F441, F463	Cross reference to the CMS – 2567 survey report ending on 2/28/2017: F157, F279, F309, F329, F371, F431, F441 and F463	
3201 **3201.1.0** **3201.1.2**			

Provider's Signature _____ Title N.H.A. Date 4/2/2017